# SURGERY

UNDER THE CHARGE OF

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**The Pathogenesis of Renal Tuberculosis According to Observations on Two Autopsy Cases.**—Heresco and Cealic (*Ann. d. mal. d. org. gén.-urin.*, 1911, ii, 1441) report two cases with autopsies, one patient dying after operation. In both cases one lung and the opposite kidney were involved by the tuberculosis, cavities being present in the affected lungs and kidneys. There were no adhesions between the visceral and diaphragmatic pleuræ, nor was there any involvement of the mediastinal or aortic lymph nodes, macroscopically or microscopically. In the first case there were found bacillary lesions of other organs, kidney, ureter, bladder, lungs, epididymis, and hip-joint. These facts seem to show that the path of propagation is by the blood, rather than by the lymph. Tendeloo has two cases in which autopsies were performed. In the first there were bacillary lesions of the lungs and tracheobronchial lymph nodes; adhesions between the right visceral and diaphragmatic pleuræ; bacillary lesions in the upper end of the right ureter; and a caseous node on the anterior surface of the vena cava. In the second case there was an enlarged and painful tracheobronchial lymph node, adhesions between the base of the right lung, the diaphragm, and the liver. The aortic nodes and those of the right renal vein were enlarged and caseous. From these two autopsies, Brongersma concluded that the primary infection is of the lung or the mediastinal nodes, and from there it is propagated by the lymph paths to the kidneys. The two cases reported by Heresco and Cealic demonstrate the opposite view, that the propagation is hematogenous.

**The Cure of Prostatic Obstruction.**—Young (*Surg., Gynec., and Obstet.*, 1911, xiii, 269) says that his first operations on the prostate, were by the suprapubic route, by which he has operated on 45 cases with a mortality of about 10 per cent. He has done the Bottini operation in 85 cases, but has abandoned it and is using the perineal route, with which his mortality has been about 3 per cent. During recent years he has operated on about 70 cases, in which neither the suprapubic nor perineal prostatectomy were suitable, by a new method—the urethroscopic median bar excision by means of a special "punch." He has had in all about 700 cases, on which he has done one or the other operation. That radical removal of a carcinomatous prostate can be done through the perineum is shown by the fact that Young has 2 cases alive and apparently well, 1 after six years, and the other case after one year. Perhaps one of the greatest advantages of the perineal operation, as Young performs it, is that after enucleation of the prostate, there exist two lateral extravesical cavities, which can easily be packed with gauze, thus completely stopping the hemorrhage, cavities which rapidly collapse after removal of the gauze on the following day, and which do not form intravesical pouches of suppuration. Another great advantage is that the patient can be up in a wheel chair within two or three days, with splendid dependent drainage. The absence of any case of death from sepsis and the remarkable freedom from lung complications is shown in a series of 450 cases of conservative perineal prostatectomy.

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**Anesthetization of the Brachial Plexus.**—Kulenkampff (*Zentralbl. f. Chir.*, 1911, xxxviii, 1337) says that Hirschel's communication on anesthetization of the brachial plexus has led him to report on his own attempts in this direction. The brachial plexus corresponds approximately to the middle of the clavicle. Here, even in fat people, it lies close under the surface, and its cords lie close together. The area to which the needle must pass, is bounded internally by the easily detected subclavian artery, externally by the clavicle and below by the first rib. The nerves lie between the scalenus anticus and medius, where they are surrounded by loose connective tissue, in which fluid easily infiltrates, so that a small quantity of the anesthetic injection will give an extensive effect. The technique was developed on Kulenkampff himself and in operations on his patients. The patient occupies a sitting position, and the subclavian artery is located by its pulsation, which can often be seen with the head in certain positions. It lies almost always where a continuation of the external jugular vein strikes the clavicle. The point of insertion of the needle is just external to this, close upon the upper edge of the clavicle. A fine hollow needle, about 4 cm. long, is made to penetrate almost to the first rib and to seek one of the nerves, when a paresthesia radiates to the arm, and there are seen signs of motor irritation; but there is no pain, as Kulenkampff observed on himself. If the direction of the needle is correct, this paresthesia develops as soon as the skin, superficial and deep fascia are penetrated. The injection of the fluid should be avoided until the paresthesia occurs in the arm, because it will eliminate the tenderness, and thus render difficult or impossible exact exploration. The needle should be directed somewhat inward, backward and downward, in the direction of the second or third dorsal spine. The plexus is about 3 cm. deep, the first rib a little deeper. If the rib is struck without the plexus being met with, it will be because fear of the subclavian artery has caused the needle to pass too far outward. The needle must then be tried successively farther inward, until the paresthesia is obtained. In adults, 10 c.c. of a 2 per cent. novocain-adrenalin solution, with the usual percentage of the latter drug, should be injected. In children, 5 c.c. will be sufficient. As a rule, in from fifteen to twenty minutes the anesthesia is present and involves the whole arm, except for a triangular area over the deltoid. There is also a severe paresis of the whole arm, and a part of the shoulder muscles. The anesthesia lasts